

# CACFP ENROLLMENT FORM

## 1. Participant Information: (To be completed by Parent/Guardian)

☐ Participants are related to the Provider

Participant's Last Name	Participant's First Name	Date of Birth	Normal/Typical Hours of Care			Normal/Typical Days of Care (Circle all that apply)							Meals Normally Eaten (Circle all that apply)						
						M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN	
				To															
				To															
				To															
				To															
				To															

\*Parent/Guardian works multiple shifts and participants may be in care different days/hours \_\_\_\_yes \_\_\_\_no

### Guide:

**Normal hours of care:** Please insert the usual arrival time and the usual departure time. Indicate a.m. or p.m.

**Normal days of care:** Please circle the days of the week the participant(s) are usually in attendance at the facility

(M=Monday; T=Tuesday; W=Wednesday; Th=Thursday; F=Friday; Sa=Saturday; Su=Sunday)

**Meals Normally Eaten**-Please circle the meals the participants usually eat at the facility.

(B=Breakfast; AM=AM Supplement; L=Lunch; PM=PM Supplement; S=Supper; LN=Late Night Supplement)

## 2. Do you supply any food to the center for the participant's meals due to medical or religious reasons?

If Yes, please list foods supplied:

## 3. Signature and Parent/Guardian Information:

Parent/Guardian Signature

Date (Parents date form)

Print Name:

Home Telephone Number:

Work Telephone Number:

Address:

City:

State:

Zip Code:

For Provider Use Only. Do not write below this line.

Signature of Provider: \_\_\_\_\_

Date: \_\_\_\_\_

Date the participant withdrew: \_\_\_\_\_

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\*7 CFR 226.15 (e)(2)